

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2011	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PLACE MERRILLVILLE, IN46410			
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/02/11</p> <p>Facility Number: 000253 Provider Number: 155362 AIM Number: 100266660</p> <p>Surveyor: Richard D. Schade, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Golden Living Center - Merrillville was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p>			K0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2011

FORM APPROVED

OMB NO. 0938-0391

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K0044 SS=E	<p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The building was constructed in 1978. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 164 and had a census of 155 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/08/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			K0044			09/01/2011
	<p>Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to</p>				<p>Fire doors in the rest of bldg were checked and closed sufficiently. Maintenance Director contacted contractor to replace push bar on</p>		

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	<p>ensure 1 of 1 fire door sets to the C wing was arranged to automatically close and latch. LSC section 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows, 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice affects all residents, staff and visitors in the facility's C wing.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 08/02/11 at 3:15 p.m. the fire doors to the C wing did not latch. The maintenance supervisor stated at the time of observation, the mechanism which should latch the door was broken and not operational.</p>				<p>door so that latch will engage. Doors presently close automatically with no gap while closed. Maintenance Director will continue to make monthly rounds in the building to ensure that Fire door sets close and latch as required. This will be ongoing.</p>		

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K0050 SS=F	<p>3.1-19(b)</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 quarters. This deficient practice could effect all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Drill records and interview on 08/02/11 at 1:50 p.m. with the maintenance supervisor, there was no record of a third shift fire drill for the second quarter of 2011. The maintenance supervisor</p>			K0050	<p>Fire drill for the 3rd shift was completed following the exit of life safety. Education was also provided to Maintenance team to ensure that rotation of shifts continued monthly to maintain compliance with Life Safety requirements. A binder has been put in place to organize fire drills and will be brought to exec director or designee to review for 100%compliance monthly. This will be ongoing.</p>		09/01/2011

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K0064 SS=E	<p>acknowledged a third shift fire drill was not conducted during the second quarter of 2011.</p> <p>3.1-9(b) 3.1-51(c)</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers in the kitchen was readily identified as a secondary backup to the automatic fire suppression system. NFPA 10, 1998 Edition, 2-3.2.1 requires fire extinguishers to include a conspicuously placed placard which states the automatic fire protection system is to be activated before using the fire extinguisher. This deficient practice affects all staff in and near the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the</p>			K0064	<p>The portable fire xtinguisher was given a tag to identify as a secondary backup.Education was provided to dietary, maintenance and housekeeping departments regarding the extinguisher being the secondary backup to the automatic fire suppression system. Fire extinguishers are checked monthly by Maintenance department and will continue to monitor to ensure that tag stays in place. this will be ongoing.</p>		09/01/2011

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K0144 SS=F	<p>maintenance supervisor on 08/02/11 at 3:25 p.m., a placard was not placed near the Class K extinguisher in the kitchen. The maintenance supervisor acknowledged there was no placard placed near the fire extinguisher.</p> <p>3.1-19(b)</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with remote manual stops. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a</p>			K0144	<p>Emergency generator company was contacted regarding manual remote stops. This will need to be custom built and material has been ordered to begin process of manufacturing item. Maintenance Director will be in communication with H&G regarding installation to ensure that all efforts are made to complete install by September 1st. Generator company also provided us with documentation for horsepower of generator and will be kept with life safety materials for future reference. Generator will continue to run weekly as scheduled to ensure proper function of equipment. This will be ongoing.</p>		09/01/2011

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	<p>type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient practice could affect all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of the Generator Maintenance records on 08/02/11 at 2:10 p.m. with the maintenance supervisor, documentation was not available which indicated the horsepower rating of the generator engine. Based on interview with the maintenance supervisor during record review, he stated no remote shut off device existed for the generator. The maintenance</p>						

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	supervisor indicated the generator was installed before 2003. 3.1-19(b)						